WOMEN'S HEALTH SERVICE REPORT

	Issue	Recommendation	Current situation	Workplan	Proposed completion date	Complete
1	Concern that the maternity review of 2012 recommendations had not been fully implemented.	**Implementing the recommendations of the 2012 report.**	Majority of the recommendations were in relation to care in the community and much has been achieved with work still on-going (MQSG and MSGG).	Maternity Strategic Governance Group (MSGG) to present update to ELT Sept 2019.	September 2019	
2	Lack of team structure to provide inpatient continuity of care to complex antenatal patients (maternity ward) and complex gynaecology patients (GCU)	**A team structure to look after obstetric and gynaecology inpatients with the aim of improving continuity of care. This will require a dedicated project manager.**	Rostering of SMOs to the daily Maty and GCU ward rounds. This was set up using a dedicated group of SMOs interested in these clinical areas, but over time it has become open to a wider group of SMOs resulting in a range of management plans.	i. [redacted] employed by Women s Health April to September 2019 at 0.5FTE as a "Change Manager" to look at this and other projects within the service. ii. Reinstitute Wednesday morning meetings to discuss complex antenatal and gynaecology patients.	Sep-19 ii. Complex case discussions commenced April 2019.	**Yes**
3	With the SMO second on-call arrangements there appears to be a reluctance to call the back-up person because they will be working the next shift. There have been issues with rostering and leave. The roster only coming out the Friday before the next week and difficulty in getting leave plus multiple last minute changes. There have been a series of rostered changes with the current employee not coping. Additional support has been provided by NRA and the job is being scoped to determine whether additional FTE is required. The master roster is not up to date with leave or swaps.	**More support for rostering and leave provision. This has the potential to move from frustration to having an effect on clinical safety.**	Immediately prior to Christmas 2018 a separate dedicated weekend on-call SMO system was put in place to avoid this. For week days, clinical duties are cancelled the following day if the second – on call has been required to work during the night. Current rostering system is disfunctional. NRA have job-sized rostering position and believe this to be 1.7 FTE, so 0.7 more than the current FTE.	Indepenndent second-on-call system at weekends Change manager to review daily rostering process; looking at replacing multiple manual activities to electronic to avoid errors. Sharepoint and other options being explored.	Dec 2018 September 2019	**Yes**
4	There is a large number of high risk women that having caesarean sections (CS) afterhours when the rest of the hospital is at its lowest staffing levels.	**An anaesthetic consultant on site after hours**	On-call anaesthetic SMO overnight		Update May 2019	**Yes 14/5/19**
5	Although the birth rate has dropped from a high of 8,225 to 7,816, the absolute number of obesity 2and 3 patients has gone up from 726 to 885. Over 50% of patients booked have a BMI of 35 or greater. Timing of emergency CS is a concern. Last year 611 were performed between 8am and 5pm; 337 between 5pm and 10pn; and 593 between 10pm and 8am.	**Expand on the audits of the outcomes for those pregnant women with BMIs of over 50. At the same time look at trying to reduce the number of emergency CS done between 10pm and 8am.**	Currently no local guideline regarding induction of labour (IOL) or elective CS in obese women.	Review of the last 12 months of data by [redacted] presented at the Women s Health update day 1/5/19. Reviewed by May '19 OCPG - recommendations to be added to the Obesity guideline and signed off by the controlled document group 9/7/19 noting that caesareans in women with morbid obesity may still happen out of hours and resources and skilled clinicians are required at all times for this service.	Jul-19	**Yes**
6	The Diabetic Clinic is a major issue. They are overwhelmed by the demand. They do not have the resource to follow the guidelines, which is adding to the stress of those working in the clinic. They are continually worried that they will miss something. Apart from lack of staff they also have concerns about lack of space to see the patients.	**The Diabetic Clinic needs more resource both in staff and physical space**	Two new SMOs have been employed since this review (with an interest in diabetes) in-part to work in the GDM clinic . Obstetric diabetes lead reinstated [redacted] with her request to review handing this over in December 2019 - [redacted] new SMO commencing with DiP interest and experience	i. Under review, proposals to be developed by [redacted] engaged as a project manager to assess current situation - report completed. Decision made to engage KA ii. Review of additional clinic space in Mangere (for low risk women) plus exploring module 10 clinics on Thursday mornings (am clinics also have a lower DNA rate) iii. Additional clinic space from portable building to adjoin Module 10.	May 2019 August 2019 Dec 2019 Feb 2020 Sept 2019 2020	
7	Inadequate number of caesarean section lists.	**All day elective LUSCS lists should be implemented.**	Over-run of elective caesarean lists on a regular basis. Insufficient lists - recently gained a Wednesday afternoon list. Mon, Tue, Thur and Friday remain half day lists (excluding PH and theatre shut-down days).	[redacted] completed: reviewing theatre flow for elective caesareans (daily overruns). To present report to acute theatre team with solutions. Decision to increase to all day theatre lists Tuesday, Wednesday and Thursday	Meeting 21/05/19 June 2019	**Yes**

WOMEN'S HEALTH SERVICE REPORT

	Issue	Recommendation	Current situation	Workplan	Proposed completion date	Complete
8	The service is also concerned about the unmet need for patients with pelvic pain and urogynaecology as they do not often meet the criteria to be seen in clinic. This particularly affects those specialists with an interest in these clinical areas.	**Outsourcing of gynaecological electives if possible should be to those gynaecologists who are employed by Counties Manukau. Exploring the possibilities of hiring facilities from private hospitals and using Counties Manuakau staff, including registrars, to ensure their operating numbers are adequate.**	Due to limited theatre capacity, P3 urogynaecology and pelvic pain patients are not seen as FSAs as they would not receive surgery in the required timeframe.	Additional resource has since been provided for outsourcing. This has commenced with working through a back-log of outpatient hysteroscopy cases (218 referred - some declined case eg performed in private/ acutely, no-longer required, uncontactable or requesting GA expect 150 completed cases by end May 2019). A procurement process has now commenced for use of a private facility with anaesthetic and nursing staff for use by DHB employed Gynaecologists and trainees. Saturday operating at MSC being explored - supported by CMH O&G and Anaesthetic SMOs and trainees Pessary clinics run by women s health physiotherapists are being explored to help with the unmet urogynaecology need.	**Completed end May 2019.** Contract to be finalised for 48 cases - surgery commences 29th August . October 2019 Oct-19	
9	One of the major issues from the gynaecologists is the lack of control over their operating lists.	**Gynaecologists should have more control over the operaitng list taking into account clinical priority and waiting time.**	i. Gynaecologists not involved in booking lists and often operate on women they meet for the first time on the day of surgery. ii. Dictated to by theatre team (cube) that TLHs will only be performed on all day lists with no consultation.	i. Operating surgeon to be able to agree list 2 weeks out and see all patients in pre-assessment clinic. ii. Meet with anaesthesia regarding TLH cases - discussed at Anaesthetic GG on 14 May 2019. [redacted] will look futher into cube data. to attend TOG and cube meeting. Discussed option of Saturday operating at MSC - surgica;l services and anaesthetics in consideration.	May 2019 May 2019 June 2019 June 2019	**Yes**
10	Low SMO morale	**A job sizing exercise for SMOs ensuring that they get adequate non-clinical time**	Current difficult roster situation, business after hours and lack of team structure. Some improvement since Dr Tait s visit with employment of 4 new SMOs and 3 additional registrars.	Change Manager employed April to September 2019 to look at daily rostering and leave, team structure and after hours roster. [redacted] will work closely with the SMO team. ASMS are aware. Job sizing will be required as part of this process. Engagement with allied health looking at a women s health psychologist for staff and patient s	September 2019 October 2019	
11	The lack of resource for the Clinical Director has resulted in her spending considerable time on sorting out rosters, fire-fighting, etc with having limited time to strategise and increase her visibility to the Service.	**Provide adequate resource to support the Clinical Director**	Lack of resource; fire fighting	Change Managers [redacted] for Ward [redacted] for SMO roster and model of care work Working alongside CD	September 2019 but may need ongoing support for future projects	
Additional items in the report but no specific Tait recommendations						
12	At present there are also a number of junior registrars which is compounding the feeling of "relentlessness" of work when the SMO is on duty	**No specific Tait recommendation**	Registrars employed through NRA regionally, with few step-up positions available in the region. Currently CM Health have an over-allocation of two registrars to function in this way.	Application made through NRA for an SHO tier of four doctors to assist transition from HO to registrar. This equates to the number of first year RANZCOG trainees joining CM Health each year. Approval granted to commence 2 positions in December 2019 and a further 2 in June 2020.	December 2019 and June 2020	**Yes (funding approved)**
13	The concerns with accreditation for training positions with RANZCOG was raised on several occasions. The last report from RANZCOG also raised that possibility with the next reaccreditation visit due in January 2020.	**No specific Tait recommendation**	[redacted] for a RANZCOG pre-accreditation visit by O&G Colleague, Dr. Devenish, on 3rd April 2019	See Devenish report recommendations, including a later re-accreditation visit with January being soon after registrar change-over and a high leave period - this has been endorsed by RANZCOG. Overall a positive report.	**RANZCOG reaccreditaiton visit March 2020**	